STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 12,913

)

Appeal of)

)

INTRODUCTION

The petitioner appeals the decision by the Department of Social Welfare denying her application for medicaid for her nine-year-old son. The issue is whether the petitioner's son meets the definition of childhood disability under the pertinent regulations.(1)

FINDINGS OF FACT

The petitioner's son has had a harrowing medical history, beginning in infancy, as briefly outlined in the following portion of a recent (October, 1994) hospital summary:

HISTORY: [D] is an 8-year-old male with renal failure diagnosed at one week of age secondary to an obstructive uropathy. He is status post a renal transplant three years previous, following an elective bilateral nephrectomy. There was a single related Haplotype kidney drawn from is father in 1991. [D] has undergone a total of 19 surgeries for his urinary tract abnormalities which as well as chronic renal failure, also include posterior urethral valves and bilateral vesiculoureteral reflux. [D] was noted to have seizure activity following the transplants and has been on Tegretol for approximately two years. The Tegretol was discontinued approximately two months ago due to lack of seizure activity and he has had no seizure activity since.

At this time, however, the boy's physical problems are relatively stable. He attends school, and intellectually he is a bright child who has been placed in a class for exceptional students.

The primary basis for the claim of disability at this time is his behavior. Apparently, these problems began following his transplant surgery in 1991. Over the past year his behavior, mostly at school, has deteriorated markedly, and a special education program, including a full-time aide, has been designed to deal with his emotional problems.

The medical evidence includes an assessment based on the in-school observations of an educational

psychologist done in May, 1994. The report includes the following comments on the child's emotional development:

[D] does exhibit a number of exceptionalities (assumed superior intellect and unique medical needs) and he deserves to acquire the critically important skills of empathy and assertiveness.

It is very easy for adults to defer to [D's] requests (sometimes presented as demands) as he has been through an enormous amount of medically related trauma, he is highly persuasive in his use of logic and rationalizations and he offers clear signals of behavioral escalation in expressing his frustration or anger. His intensity of behavioral acting out not only is highly potentially dangerous to himself and others but the concessions by adults within this context encourages his inappropriately expressed demands. These concessions may have an immediate gain at the expense of a long-term loss. At these times [D] clearly learns that he is not accountable for a transgression of a school rule, and he is reenforced for his use of physical acting out to communicate his feelings of apprehension (of a suspected pending reprimand) or disappointment (when told he cannot do what he wants to do).

Developmentally, [D] is not able to assume the level of personal responsibility that is commensurate with his mental age. By this, I mean that he is a very bright child who is apparently assimilating academic skills (reading, math, etc.) at a rate that is far ahead of most of his peers. He is in specific need of learning the valuable interpersonal skills such as: taking turns, deferring to decisions of others, respecting parental and adult authority, negotiating the differences, agreeing to disagree, using empathy as an internal deterrent of offensive behaviors (appreciating how his behavior would impact others), respecting his own property and the property of others, and speaking to others in respectful ways. In order for [D] to access people and educational experiences that would allow him to learn to grow to his full potential, it is essential that he develop an interpersonal demeanor of respect and to reduce his egocentric perspective. The egocentricity of all children begins to give way to an appreciation of mutual (self and others) perspectives at about the age of five. This aspect of development is directly related to their social experiences.

Among the report's recommendations was the need for both the school and the child's parents to develop and implement an "intensive behavior plan" to modify and monitor his negative behaviors.

Reports indicate that by November, 1994, the child's behavior in school had become "very aggressive and non-compliant . . . to the point of requiring one-to-one attention with an aide and removal from his classroom". As noted above, he was hospitalized in October, 1994, for an extensive medical evaluation of his behavioral problems. No neurological problems were found, but a psychiatric diagnosis of Attention Deficit Hyperactivity Disorder was noted.

A comprehensive psychological assessment was performed in November, 1994. The report of that assessment contains the following summary and diagnosis:

[D] is a bright youngster with a complicated history and complex presentation. He possesses exceptional reasoning skills and can be expected to demonstrate high academic achievement. [D] appears distractible and may have difficulty maximizing his potential due to attentional limitations which may be products of his hearing impairment, selective inattention, biologically based problems in attention and/or emotional overstimulation. Projective testing suggested that at the time of testing [D] was flooded and disorganized by strong feelings, overstimulated by aggressive imagery and fantasy, and had difficulty feeling good about himself and maintaining self-control in his interactions with others. His apparently

overloaded state is likely to be related to his medical history and its sequelae, uncomfortable interactions at school, other issues or a combination of these. Teacher and parent ratings are consistent with projective data suggesting problems in self-control, anxiety and anger management, and social functioning. All sources of information suggest that [D] struggles with rage, feelings of helplessness, and a need to discharge the tension he feels.

In addition to the losses reported by [D's] parents he continues to need to grieve the loss of body integrity and lost possibilities. [D] appears very confused and anxious about his situation and seems to have tried to cope with strong feelings by gaining information about his condition and the human body. It is suggested that the aim of mastery over distress and anxiety has not been met and that [D] remains fixated at a level of social and emotional development which precedes his chronological and cognitive levels.

Also in November, 1994, the child's treating psychologist submitted the following report:

Findings: I have met with the client and his family since August of this year. In regard to his psychological status, he has primarily displayed problems with uncooperative behaviors that have to explosive angry outbursts across settings. There is not evidence to suggest a thought or mood disorder. He is capable of understanding, remembering and carrying out instructions. However, he has exhibited periods of responding in a reactive way to supervision.

The above reports make clear that for at least the past year the petitioner's son has had extreme difficulty interacting with his peers and authority figures. This has resulted in frequent episodes of aggressive, impulsive, and disruptive behavior. His educational program has required continuous one-on-one monitoring and supervision by a specially assigned teachers aide and prolonged periods of separation from activities with his peers.

While it is difficult, and in some ways conjectural, to evaluate what restrictions a child's emotional problems might impose if that child were an adult, in this case it is obvious that an adult with the petitioner's son's emotional problems would be totally dysfunctional in a competitive work setting. As discussed below, an adult with the documented problems the petitioner's son has would clearly meet the "Listings" of a mental impairment under the regulations, which result in a presumptive finding of disability.

ORDER

The Department's decision is reversed.

REASONS

Medicaid Manual Section M 211.2 defines disability as follows:

Disability is the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, or combination of impairments, which can be expected to

result in death or has lasted or can be expected to last for a continuous period of not fewer than twelve (12) months. To meet this definition, the applicant must have a severe impairment, which makes him/her unable to do his/her previous work or any other substantial gainful activity which exists in the national economy. To determine whether the client is able to do any other work, the client's residual functional capacity, age, education, and work experience is considered.

For a child under age 18, the regulations provide that a determination of disability is made when the child has an impairment "which compares in severity to any impairment(s) that would make an adult disabled", and that the "Listings" of impairments that are used to determine disability for adults also apply to children. 20 C.F.R. § 416.924. Under the "Listings" (20 C.F.R. § 404, Subpart P, Appendix I) an individual is presumed disabled if he meets the following symptoms of a "personality disorder":

12.08 PERSONALITY DISORDERS:

A personality disorder exists when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress. Characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Deeply ingrained, maladaptive patterns of behavior associated with one of the following:

1. Seclusiveness or autistic thinking; or

2. Pathologically inappropriate suspiciousness or hostility; or

3. Oddities of thought, perception, speech and behavior; or

4. Persistent disturbances of mood or affect; or

5. Pathological dependence, passivity, or aggressivity; or

6. Intense and unstable interpersonal relationships and impulsive and damaging behavior;

AND

B. Resulting in three of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to compete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

The evidence in this case clearly establishes that the petitioner's son meets the above Listing.(2) The medical evidence speaks specifically to the child's problems with "interpersonal relationships and impulsive and damaging behavior" (A6) and problems with "maintaining social functioning" (B2), "concentration" (B3), and "deterioration in work-like settings" (B4). Requiring a full-time aide to monitor and control one's behavior is certainly also a "marked restriction of activities of daily living" (B1).

In light of the foregoing, the Department's decision is reversed.

# # #

1. The petitioner does not appeal the decision denying her son benefits under DCHC, a program of enhanced coverage and relaxed financial eligibility provisions for children who receive home health services as an alternative to institutional care.

2. The Department's (DDS's) decision in this matter appears to be based on a single phone call a disability examiner had with the child's teacher's aide in December, 1994, at which time the aide reported that the child had recently been able to spend five consecutive days in his regular classroom. In light of the overwhelming medical evidence (summarized above), to conclude (as DDS apparently did solely from that conversation) that the child's psychological problems were no longer severe strikes the hearing officer as unfairly selective and naive.